STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division for Children, Youth, and Families
Child Development Bureau

Form 2690
July 2015

VERIFICATION FOR A CHILD EXPERIENCING SIGNIFICANT SPECIAL NEEDS

To encourage providers to accept and retain children eligible for Child Care Scholarship experiencing a significant special need(s), the Department will pay a supplemental rate to DHHS enrolled child care providers caring for children with a verified diagnosed disability. The special need(s) must rise to the level of requiring additional funding for accommodations or adaptations by the child care provider.

Full Name of Child _____ **Child's RID #** _____

SECTION I: CHILD CARE PROVIDER

Name: _____ Phone #: _____

Business Name: _____ Provider Resource ID #: _____

Address: _____

☐ I certify that the child's special need(s) is significant enough that the child requires additional funds for accommodation or classroom adaptation in the child care setting.

The planned accommodation(s) or adaptation(s) for this child is:

_____ _____

Child Care Provider's Signature **Date**

SECTION II: LICENSED PROFESSIONAL (CAN NOT BE COMPLETED BY THE CHILD CARE PROVIDER)

Name: _____ Phone #: _____

Business Name: _____

Address: _____

The child's special need(s) is: (CHECK AS MANY AS APPLY)

☐ medical ☐ physical ☐ developmental ☐ educational ☐ emotional

If the licensed professional above is the child's attending physician, physician's assistant, advanced practice registered nurse or licensed mental health professional complete the information below:

The diagnosis of the child's special need is: _____

Is this a permanent condition? ☐ Yes ☐ No If no, length of expected duration is: _____

☐ I certify that: I am the child's attending physician, physician's assistant, advance practice registered nurse, or licensed mental health professional, and am providing ongoing treatment; the child's special need(s) is significant enough that the child requires additional support in a child care setting; and, if the child is 13 through 17 years of age, the child's condition limits the child's ability to care for himself/herself or he/she would cause harm to himself/herself or others without supervision.

_____ _____ _____

Signature **Title** **Date**

If the licensed professional above is the SAU Special Education Director or Area Agency Director complete the information below:

The child has a current Individual Education Plan, Individual Family Services Plan, or 504 plan ☐ Yes ☐ No

☐ I certify that: I am a SAU Special Education Director or an Area Agency Director and the child's special need(s) is significant enough that the child requires additional support in a child care setting.

_____ _____ _____

Signature **Title** **Date**

SECTION III: PARENT/GUARDIAN

Parent/Guardian Name: _____ Phone #: _____

Address: _____

By signing below, I authorize this verification to be released to the Department of Health and Human Services. I understand that the information will be held in the strictest confidence and that it will be reviewed by, or shared with, authorized Department of Health & Human Services' staff involved in the authorization of Child Care and Development Fund Scholarships. For chronic non-changing special needs verification is required only once. For all others verification is required annually.

Parent/Guardian's Signature: _____ **Date:** _____

STATE OF NEW HAMPSHIRE
Department of Health and Human Services
Division for Children, Youth, and Families
Child Development Bureau

Form 2690(i)
July 2015

Instructions to the "Verification for a Child Experiencing Significant Special Needs"

PURPOSE:

The "Verification for a Child Experiencing Significant Special Needs" is used to verify that a child has a medical, physical, developmental, educational and/or emotional disability and is eligible to receive the differential rate for the Child Care Scholarship.

INSTRUCTIONS:

The provider, professional and parent/guardian who can verify the child's special need must print or type the information to complete Form 2690 (formerly 2628). For Employment Related Child Care, Form 2690 is provided to the family at the initial eligibility interview or upon request if the child is likely to have a special need. For Preventive and Protective Child Care, Form 2690 is made available by the Child Protective Service Worker (CPSW) or Family Resource Center if the child is likely to have a special need. The parent/guardian must sign and date the form, authorizing the release of information to DHHS and provide it to the child's attending Physician, Physician's Assistant, Advance Practice Registered Nurse, or Licensed Mental Health Professional **OR** School District Special Education Department, or Area Agency Director who can verify the special need and return it as below. All sections **MUST** be complete. An incomplete form will **NOT** be accepted and no differential rate will be authorized.

FORM COMPLETION:

SECTION I: Provider:
Enter the child's full name
Enter the child's RID number
Enter the provider's name, telephone number, business name, if applicable, provider resource ID number and address
Check off the certification that the child requires additional funds for accommodation or classroom adaptation and indicate what the planned accommodation or adaptation is for the child. The differential payment will not be authorized if the child does not require additional funds for accommodation or classroom adaptation.
Sign and date the form

SECTION II: Licensed Professional (Licensed Health Professional OR Licensed Educational/Area Agency):
Enter the professional's full name, telephone number, business name, if applicable and address
Indicate the child's special need

If the licensed professional is the child's attending Physician, Physician's Assistant, Advanced Practice Registered Nurse or Licensed Mental Health Professional:
Enter the child's diagnosis
Indicate if this is a permanent condition and if not the length of the expected duration
Check the box certifying the professional's role and the special need is significant enough to require additional support in a child care setting; and if the child is 13 through 17 years of age, the child's condition limits the child's ability to care for himself/herself or he/she would cause harm to himself/herself or others without supervision.
Sign, enter the professional's title and date the form

If the licensed professional is the SAU Special Education Director or Area Agency Director:
Indicate if the child has a current IEP or 504 plan
Check the box certifying the professional's role and the special need is significant enough to require additional support in a child care setting.
Sign, enter the professional's title and date the form

The differential becomes effective the first Monday following the date of signature of the licensed professional.
This section must be completed by the licensed professional **NOT** the child care provider.

SECTION III: Parent/Guardian:
Enter parent's full name, telephone number, and address
Sign and date the form to authorize the release of information
Provide the form to the licensed professional for verification

Either the parent or licensed professional may return the completed form to DHHS. For **Employment Related Child Care** this form must be returned to: DHHS Centralized Scanning Unit, P.O. Box 181, Concord, NH 03301. For **DCYF Preventive and Protective Child Care** the form must be returned to: DHHS/DCYF Provider Relations, 129 Pleasant Street, Concord, NH 03301.

RETENTION:

Form 2690 is retained in the eligibility record or at State Office.